Lessons From the Practice

Pandora's Box

MITCHELL D. FELDMAN, MD, MPhil, *San Francisco, California*

Even before we exchanged a single word, there were several clues that in retrospect should have aroused my suspicions when I looked at her chart and walked out into the waiting area: a vague chief complaint obtained by the triage nurse, a hesitant, frightened manner, an anxious-appearing husband. But she was Asian and well dressed, as was her husband, and the last thing I expected to uncover that day in the busy urgent care setting of a university medical center was violence. And because it was so unexpected, I will never forget that afternoon.

She sat down in my office, and I tried to understand the nature of her chief complaint. She reported that she had fallen a few days earlier and was worried about persistent chest pain. The circumstances of her fall and the exact nature of her discomfort were vague, but I attributed this, in part, to cultural differences, and although perplexed, I was not concerned. Because she was young and appeared relatively healthy, I thought it unlikely that her chest pain would require emergent or even urgent evaluation. So I settled back and asked the kind of open-ended questions that I had been taught would be useful.

Her answers did not help me to understand why she had come to the clinic. She thought she might need an x-ray examination and seemed anxious to leave when I did not immediately agree. She appeared uncomfortable; I remained puzzled. Why and how she fell were questions left unanswered, but I did not pursue them because I did not want to add to her discomfort—or, perhaps less consciously, to mine.

I had completed three years of training at one of the top internal medicine training programs in the country, but had never been taught anything about domestic violence. I did not know it, but my education in this crucial area had begun.

The patient agreed to a physical examination, and I stepped out of the room while she changed into a gown. I was conscious of the many other people in the waiting area that day and had already decided that a directed examination followed by some reassurance could likely terminate our encounter in a few minutes. But I remained puzzled by the lack of clarity in her story.

I reentered the room and began a cursory examination. I noticed that she had tied the gown securely around her—in retrospect, in an almost protective embrace. Her serious, distant demeanor added to my desire to terminate the visit rapidly. I went around to her back, put on my stethoscope, and began listening to her lungs. As I lifted the gown in the back to listen to the upper lung fields, the bottom margin of a large ecchymosis became visible.

In that instant, many conflicting thoughts and emotions descended on me. A part of me wanted to pull the gown back down and get on to the next patient. I finally asked, "Who did this to you?" She appeared frightened, but admitted that her husband had "pushed" her. I felt angry, sad, and helpless. I felt ashamed. I asked her more questions about what had happened and whether anything like it had ever happened before, but she was anxious, withdrawn, and reluctant to speak. I asked her to get dressed and left the examining room. Pandora's box was open, and somehow I would have to deal with it.

I walked to the conference area and found myself staring at the bookshelf. When confronted with what appears to be a clinical conundrum, I often face that wall of books with the perhaps magical wish that the answer will be revealed by the accumulated facts and wisdom before me. Eventually, I select a text (or several) and start reading until an approach to the problem becomes clear. On that date, however, no answer emerged.

A nurse practitioner in the clinic noticed my distress and asked if she could help. Grateful for her support, I described what had happened and what I was feeling. She gave me the name of a shelter and suggested I tell the patient, "No one has the right to do this to you!"

Relieved to have at least some semblance of a plan, I went back to the examining room and handed the shelter's telephone number to the patient. I naively expected her to express appreciation and to call the shelter immediately. I implied that she could not possibly go back home with the person who had inflicted such pain on her.

To my dismay, she took the piece of paper with the telephone number, repeatedly folded it until it was no bigger than a postage stamp, and buried it deep in her purse. I asked again if she wanted to use the phone, but she appeared as she had when I had left the room earlier—shaken, frightened, and resigned. I repeated that nobody had the right to hurt her. This seemed to have a calming effect as she stood up to leave. I opened the door, and she walked back toward her husband in the waiting area.

Not more than a half hour had elapsed, but I felt as

(Feldman MD. Pandora's box. West J Med 1997 Feb; 166:157–158)

From the Division of General Internal Medicine, Center for AIDS Prevention Studies, University of California, San Francisco (UCSF), School of Medicine.

Reprint requests to Mitchell D. Feldman, MD, MPhil, Division of General Internal Medicine, UCSF School of Medicine, 400 Parnassus Ave, Box 0320, San Francisco, CA 94143.

drained as I ever had during a difficult resuscitation in the hospital. Unable to go immediately on to the next patient, I took a break and reflected on what had happened and whether I could have done more.

I now ask all my female patients about past or current abuse and am astonished at its prevalence. I realize that I must have cared for many other battered women in the past, but had been oblivious to their true "chief complaint." Undoubtedly there are other well-meaning but inadequately trained physicians who are unaware that many of the women they are caring for have been battered.

I have often wished that I could have had another try with that patient on that busy afternoon. I would have obtained a much more detailed history of past physical or sexual abuse and learned whether it was an escalation of abuse that had brought her to the clinic. I would have asked about the presence of weapons and children in the house and made her aware of her legal options. I would not have in any way suggested that she should not return to her husband. That was a decision only she could make; my role would have been to help support her in whatever decision she arrived at.

Wherever she is, I hope that she is safe. I remain grateful to her for beginning my education in domestic violence.

* * *

"Lessons From the Practice" presents a personal experience of practicing physicians, residents, and medical students that made a lasting impression on the author. These pieces will speak to the art of medicine and to the primary goals of medical practice—to heal and to care for others. Physicians interested in contributing to the series are encouraged to submit their "lessons" to the series' editors.

JONATHAN E. RODNICK, MD
STEPHEN J. McPHEE, MD
Assistant Editors